STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

QME APPOINTMENT NOTIFICATION FORM

To the Qualified Medical Evaluator: You are required by law to give notice on this form when an appointment has been made with you to perform a QME comprehensive medical evaluation. Please complete this form in its entirety. You are legally required to include: the name and address of the employee, the name of the employer and claims administrator, and the appointment time and date. The Administrative Director also requires that you serve this appointment notification form on the employee and the claims administrator, or if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical evaluation. You also must use this form if you refer the injured worker for a consultation to advise the parties of the date and time of the appointment with the consulting physician (See, 8 Cal. Code Regs. § 32). You may not cancel the appointment les than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34 and 41(a)(7) and (a)(8)).

EMPLOYEE INFORMATION

NAME: Jonathan Shockley

ADDRESS: 1000 Sutter Street Room SAN FRANCISCO, CA 94109
City *State* *Zip*

PHONE: _____ SOCIAL SECURITY No.: 217-25-7160
(Social Security Number is for record-keeping purposes only.)

DATE OF INJURY: 02/15/2019 PANEL No.: _____ CLAIM/CASE No.: 7173815490

EMPLOYER INFORMATION

NAME: CARDIONET LLC

ADDRESS: _____
City *State* *Zip*

PHONE: _____

CLAIMS ADMINISTRATOR INFORMATION

NAME: MARIO, CASTRO

COMPANY: CHUBB GROUP INSURANCE

ADDRESS: P.O. BOX 42065 PHOENIX, AZ 85080
City *State* *Zip*

PHONE: 213-612-5378

APPOINTMENT INFORMATION

DATE OF APPOINTMENT CALL: 11/18/2019 DATE OF APPOINTMENT: 01/23/2020 TIME OF APPOINTMENT: 01:00PM

LOCATION OF APPOINTMENT: 490 Post Street, Suite 900 SAN FRANCISCO, CA 941021401

CERTIFIED INTERPRETER REQUIRED: (LANGUAGE) English

COPY TO: ☑ EMPLOYEE (and employee's attorney, if known)

☑ CLAIMS ADMINISTRATOR (and attorney, if known)

SIGNATURE OF QME: _____

QME NAME (print/type): Adam Stoller, MD

ADDRESS AND PHONE: MAIL ALL RECORDS TO 1900 O'Farrell St. Suite 190 San Mateo, CA 94403 650-306-9491

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU)(Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. § 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also providehe employee with a DWC-AD form 100 (DEU)(Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

CANCELLATION POLICY: 7 BUSINESS DAYS PRIOR TO APPOINTMENT OR $937.50 FEE.
PLEASE SEND PAPER COPIES OF MEDICAL RECORDS 3 WEEKS IN ADVANCE. NO CDs,